Complete Summary

GUIDELINE TITLE

2001 consensus guidelines for the management of women with cervical intraepithelial neoplasia.

BIBLIOGRAPHIC SOURCE(S)

Wright TC Jr, Cox JT, Massad LS, Carlson J, Twiggs LB, Wilkinson EJ. 2001 consensus guidelines for the management of women with cervical intraepithelial neoplasia. Am J Obstet Gynecol 2003 Jul;189(1):295-304. [90 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Cervical intraepithelial neoplasia (CIN) (grade 1 [low-grade precursors] or grade 2, 3 [high-grade precursors])
- Invasive cervical carcinoma

GUIDELINE CATEGORY

Management
Prevention

CLINICAL SPECIALTY

Family Practice
Obstetrics and Gynecology
Oncology
Pathology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Plans
Managed Care Organizations
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To provide consensus guidelines for the management of women with histologically confirmed cervical intraepithelial neoplasia (CIN) that can act as a precursor to invasive cervical cancer

TARGET POPULATION

Women with cervical intraepithelial neoplasia (CIN)

INTERVENTIONS AND PRACTICES CONSIDERED

Biopsy Confirmed Cervical Intraepithelial Neoplasia Grade I (CIN 1)

Satisfactory Colposcopy

1. No treatment
2. Ablative or excisional methods

Follow-up without Treatment (see "Major Recommendations" field for context)

1. Repeat Papanicolaou test (PAP)
2. Human papillomavirus (HPV) testing (preferred)
3. Colposcopy
4. Annual cytologic screening
5. Repeat cytology or combination repeat cytology and colposcopy

Treatment

1. Cryotherapy
2. Laser ablation (proceeded by endocervical sampling)
3. Loop electrosurgical excision procedure (LEEP)
4. Excisional methods

Unsatisfactory Colposcopy

1. Diagnostic excisional procedure
2. Follow-up for pregnant women (follow-up optional for adolescents and immunosuppressed women)

Biopsy Confirmed Cervical Intraepithelial Neoplasia Grade II and III (CIN 2, 3)

Initial Management

Satisfactory Colposcopy

1. Ablative and excisional methods
2. Excision methods (recurrent CIN-2,3)

Unsatisfactory Colposcopy

Excisional methods

Unacceptable Practices

1. Observation with sequential cytology and colposcopy
2. Hysterectomy

Follow-up after Treatment (see "Major Recommendations" field for context)

1. Cytology
2. Combination cytology and colposcopy
3. HPV deoxyribonucleic acid (DNA) testing
4. Colposcopy

Unacceptable Practices

1. Repeat conization based on single positive HPV test
2. Hysterectomy based on single positive HPV test

CIN Identified at the Margins of a Diagnostic Excisional Procedure or in a Postprocedure Endocervical Sampling (see "Major Recommendations" field for context)

1. Colposcopic examination and endocervical sampling (preferred at 4-6 month follow-up)
2. Repeat diagnostic excisional procedure
3. Hysterectomy

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of testing (Papanicolaou, colposcopy, human papillomavirus [HPV], cervical cytology, endocervical sampling)
- Rate of invasive cervical cancer after treatment
- Rate of recurrent/persistent cervical intraepithelial neoplasia (CIN)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer performed searches of the U.S. Library of Medicine's MEDLINE database for English-language articles published between 1988 and 2001.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence

I. Evidence from at least one randomized controlled trial
II. Evidence from at least one clinical trial without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), or from multiple time-series studies, or dramatic results from uncontrolled experiments
III. Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Abstracts of articles were reviewed to determine whether they fulfilled a minimum, predetermined scientific standard.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Consensus Development Conference)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

From September 6 through 8, 2001, the American Society for Colposcopy and Cervical Pathology (ASCCP) hosted a consensus conference in Bethesda, MD, to develop evidence-based guidelines for the management of women with cervical cytological abnormalities and cervical cancer precursors. To ensure that the guidelines reflect the needs of the diverse array of clinicians providing cervical cancer screening, the consensus conference included representatives from 29 participating professional and health organizations and federal agencies. Input from the professional community at large was obtained using a novel approach that incorporated Internet-based discussion groups.

At the consensus conference, guidelines were discussed together with the supporting data, revised if necessary, and voted upon. All guidelines were accepted by a minimum of a two-thirds majority vote.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of Recommendation

A. Good evidence for efficacy and substantial clinical benefit support recommendations for use.
B. Moderate evidence for efficacy or only limited clinical benefit supports recommendation for use.
C. Evidence for efficacy is insufficient to support a recommendation for or against use, but recommendations may be made on other grounds.
D. Moderate evidence for lack of efficacy or for adverse outcome supports a recommendation against use.
E. Good evidence for lack of efficacy or for adverse outcome supports a recommendation against use.

Terminology*

Recommended: Good data to support use when only one option is available.

Preferred: Option is the best (or one of the best) when there are multiple other options.

Acceptable: One of multiple options when either there are data indicating that another approach is superior or when there are no data to favor any single option.

Unacceptable: Good data against use.

*The assignment of these terms represents an opinion or vote by the consensus conference, and the assignment is not directly linked to the "strength of the recommendation" or the "quality of the evidence."

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Draft guidelines were posted on the American Society for Colposcopy and Cervical Pathology (ASCCP) Internet Web site bulletin boards for public comment. At the consensus conference, guidelines were individually presented, discussed, revised if necessary, and voted upon. All guidelines were accepted by a minimum of a two-thirds majority vote. Multiple iterations of the revision/review process were allowed at the meeting.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The ratings of the strength of recommendation (A-E), the quality of the evidence (I-III), and terminology used by the consensus conference (recommended, preferred, acceptable, unacceptable) are repeated at the end of the Major Recommendations.

Recommendations for Managing Women with Biopsy-confirmed CIN-1

Women with Satisfactory Colposcopic Examination

Management options for women with biopsy-confirmed cervical intraepithelial neoplasia grade 1 (CIN-1) are follow-up without treatment or treatment with the use of ablative or excisional modalities (see Table II in the original guidelines). Follow-up with a program of either repeat cervical cytology, at 6 and 12 months, or human papillomavirus (HPV) deoxyribonucleic acid (DNA) testing for high-risk types of HPV at 12 months, is the preferred management approach for women with biopsy-confirmed CIN-1 and a satisfactory colposcopic examination (AII).

When follow-up is used, referral to colposcopy is preferred if a repeat cytology is reported as atypical squamous cells (ASC) or greater or the woman is high-risk HPV DNA positive at 12 months (AII).

After 2 negative, consecutive cervical cytology tests or a negative DNA test for high-risk types of HPV at 12 months, it is preferred that patients return to annual cytologic screening (BII).

In clinical settings where colposcopy is available, a combination of repeat cytology and colposcopic examination at 12 months is an acceptable approach to follow-up (AII).

Women found to have cytologic or combined cytologic and colposcopic regression during follow-up continue to be at higher risk, and it is recommended that they have follow-up with repeat cytology at 12 months (BIII).

The decision to treat persistent CIN-1 should be based on patient and provider preferences (BIII).

Provided the colposcopic examination is satisfactory and treatment is selected, the following treatment modalities for biopsy-confirmed CIN-1 are considered acceptable: cryotherapy, electrofulguration, laser ablation, cold coagulation, and loop electrosurgical excision procedure (LEEP) (AI). If treatment is selected, the choice of treatment should be determined by the judgment of the clinician and should be guided by experience, resources, and clinical value for the specific patient (AI).

It is recommended that endocervical sampling be performed before ablation of CIN-1 (AII).

Excisional modalities are preferred for patients who have recurrent biopsy-confirmed CIN-1 after undergoing previous ablative therapy (BII).

Women with Unsatisfactory Colposcopic Examination

The preferred treatment for patients with biopsy-confirmed CIN-1 and an unsatisfactory colposcopic examination is a diagnostic excisional procedure (i.e., loop electrosurgical excision procedure, laser conization, or cold-knife conization) (AII).

Exceptions where follow-up are acceptable are pregnant and immunosuppressed women (see CIN-2 and CIN-3 special circumstances), and adolescent women in whom, based on limited experience, CIN-2 and CIN-3 are rare in the setting of biopsy-confirmed CIN-1 and an unsatisfactory colposcopy (CIII).

Unacceptable Treatment Approaches

Ablative procedures are unacceptable for CIN-1 in patients with an unsatisfactory colposcopic examination (EII).

Podophyllin or podophyllin-related products are unacceptable for use in the vagina or on the cervix (EII).

Hysterectomy as the primary and principal treatment for biopsy-confirmed CIN-1 is unacceptable (EII).

Recommendations for Managing Women with CIN-2,3

Initial Management of Biopsy-confirmed CIN-2,3

Management decisions in women with biopsy-confirmed CIN-2,3 are determined by whether the colposcopic examination is classified as satisfactory or unsatisfactory, (see Table II in the original guideline document). Both excision

and ablation of the transformation zone are acceptable for women with biopsy-confirmed CIN-2,3 and a satisfactory colposcopy (AI). However, in patients with recurrent CIN-2,3, excisional modalities are preferred (AII). A diagnostic excisional procedure is recommended for women with biopsy-confirmed CIN-2,3 and unsatisfactory colposcopy (AII).

Observation of CIN-2,3 with sequential cytology and colposcopy is unacceptable except in special circumstances (see below) (EII).

Hysterectomy is unacceptable as primary therapy for CIN-2,3 (EII).

Follow-up after Treatment of Biopsy-confirmed CIN-2,3

After treatment of CIN-2,3, follow-up using either cervical cytology or a combination of cervical cytology and colposcopy at 4- to 6-month intervals until at least 3 cytologic results are "negative for squamous intraepithelial lesion or malignancy" is acceptable (AII). Annual cytology follow-up is recommended thereafter (AII).

During cytologic follow-up, the recommended threshold for referral to colposcopy is a result of atypical squamous cells (ASC) or greater (AII).

HPV testing performed at least 6 months after treatment is acceptable for surveillance (BII). If high-risk types of HPV are identified, colposcopy is recommended (BIII). If HPV testing is negative, triage to annual cytology follow-up is recommended (BIII).

Repeat conization or hysterectomy based on a single positive HPV test that is not corroborated by other findings (cytology, colposcopy, histology) is unacceptable (DIII).

If CIN is identified at the margins of a diagnostic excisional procedure or in a postprocedure endocervical sampling, it is preferred that the 4- to 6-month follow-up visit include a colposcopic examination and an endocervical sampling (BII). When CIN-2,3 is identified at the endocervical margins or in the endocervical sampling obtained after the diagnostic excisional procedure, a repeat diagnostic excisional procedure is acceptable (AII).

Hysterectomy is acceptable in this situation when repeat diagnostic excision is not feasible (BII). Hysterectomy is acceptable for treatment of recurrent/persistent biopsy-confirmed CIN-2,3 (BII).

Special Circumstances

Observation with colposcopy and cytology at 4- to 6-month intervals for 1 year is acceptable for adolescents with biopsy-confirmed CIN-2, provided colposcopy is satisfactory, endocervical sampling is negative, and the patient accepts the risk of occult disease (BII).

Ablation or excision is required for adolescent women with CIN-3 (BIII).

Definitions:

Strength of Recommendation

A. Good evidence for efficacy and substantial clinical benefit support recommendations for use.
B. Moderate evidence for efficacy or only limited clinical benefit supports recommendation for use.
C. Evidence for efficacy is insufficient to support a recommendation for or against use, but recommendations may be made on other grounds.
D. Moderate evidence for lack of efficacy or for adverse outcome supports a recommendation against use.
E. Good evidence for lack of efficacy or for adverse outcome supports a recommendation against use.

Quality of Evidence

I. Evidence from at least one randomized controlled trial
II. Evidence from at least one clinical trial without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), or from multiple time-series studies, or dramatic results from uncontrolled experiments
III. Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees

Terminology*

Recommended: Good data to support use when only one option is available.

Preferred: Option is the best (or one of the best) when there are multiple other options.

Acceptable: One of multiple options when either there are data indicating that another approach is superior or when there are no data to favor any single option.

Unacceptable: Good data against use.

*The assignment of these terms represents an opinion or vote by the consensus conference, and the assignment is not directly linked to the "strength of the recommendation" or the "quality of the evidence."

CLINICAL ALGORITHM(S)

The following algorithms are available in Portable Document Format (PDF) on the American Society of Colposcopy and Cervical Pathology Web site:

- Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN 1) and Satisfactory Colposcopy
- Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN 1) and Unsatisfactory Colposcopy

- Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 2 and 3 (CIN 2, 3)

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

In instances in which published data pertaining to a key issue were missing, scant, or conflicting, evidence brought to the meeting by the expert conference participants and expert opinions expressed on the Internet bulletin boards or by members of the working group were used to help formulate the guidelines.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Benefits

Appropriate management of cervical intraepithelial neoplasia (CIN) as prevention in the development of cervical cancer

Specific Benefits

Follow-up of Biopsy-confirmed CIN-1 without Treatment

- Prospective follow-up studies suggest that women with biopsy-confirmed CIN-1 can be safely followed by using a program of repeat cervical cytology similar to that considered acceptable for women with a cytologic diagnosis of atypical squamous cells of undetermined significance (ASC-US).
- The National Cancer Institute's ASCUS/LSIL Triage Study (ALTS) longitudinal follow-up data combined with evidence that only persistent human papillomavirus (HPV) progresses to CIN-3, and that testing for high-risk HPV detects most CIN-3, indicates that HPV deoxyribonucleic acid (DNA) testing at 12 months provides an acceptable follow-up approach for women with CIN-1.

Treatment of Biopsy-confirmed CIN-1

A number of studies have shown that pretreatment endocervical sampling can help identify women with occult invasive cervical cancer.

Post-treatment Follow-up of Biopsy-confirmed CIN-2,3

Recent studies have reported relatively high rates of clearance of HPV DNA from the cervix after successful treatment and suggest that HPV DNA testing may be a useful tool in posttreatment surveillance.

POTENTIAL HARMS

- The poor reproducibility of the histologic diagnosis of cervical intraepithelial neoplasia (CIN)-1, as well as the uncertain biologic potential of lesions that are classified on the basis of their histologic appearance as CIN-1, makes management of these women problematic. It is also important to note that with the use of either cytologic or histologic methods alone, it is impossible to determine whether a CIN-1 that appears to be persistent is a truly persistent lesion or represents a new lesion.
- Hysterectomy carries a substantially greater risk of morbidity, and even mortality, when compared with excisional and ablative procedures.
- The use of diagnostic excisional procedures during pregnancy should be limited to women in whom invasive cancer cannot be ruled out. Excisional procedures, including loop electrosurgical excisions and cold-knife conizations, performed during pregnancy are associated with complications that include significant bleeding and preterm births. They are also frequently nondiagnostic and have a high rate of recurrent/persistent disease. In 1 study, 47% of pregnant women undergoing loop electrosurgical excisions had residual CIN identified postpartum.
- There is a high rate of recurrence/persistence of CIN-2,3 after treatment in women infected with human immunodeficiency virus-1 (HIV) and the level of risk correlates with the level of immunosuppression.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The guidelines should never be a substitute for clinical judgment. Clinicians need to practice clinical discretion when applying a guideline to an individual patient since it is impossible to develop guidelines that apply to all situations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Wright TC Jr, Cox JT, Massad LS, Carlson J, Twiggs LB, Wilkinson EJ. 2001 consensus guidelines for the management of women with cervical intraepithelial neoplasia. Am J Obstet Gynecol 2003 Jul;189(1):295-304. [90 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Jul

GUIDELINE DEVELOPER(S)

American Society for Colposcopy and Cervical Pathology - Medical Specialty Society

GUIDELINE DEVELOPER COMMENT

In September 2001, the American Society for Colposcopy and Cervical Pathology (ASCCP) held a consensus workshop to develop evidence-supported consensus-based guidelines for the management of women with cytologic abnormalities and cervical cancer precursors. This meeting had representatives from 29 participating professional organizations, federal agencies, and national and international health organizations.

Participating organizations included the Agency for Healthcare Research and Quality, American Academy of Family Physicians, American Cancer Society, American College Health Association, American College of Obstetricians and Gynecologists, American Medical Women's Association, American Social Health Association, American Society for Clinical Pathologists, American Society for Colposcopy and Cervical Pathology, American Society of Cytopathology, Association of Reproductive Health Professionals, Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, Centers for Disease Control and Prevention, Division of Laboratory Systems, Centers for Medicaid and Medicare Services, College of American Pathologists, Eurogin, Food and Drug Administration, International Federation for Cervical Pathology and Colposcopy, International Gynecologic Cancer Society, International Society of Gynecological Pathologists, National Cancer Institute, National Association of Nurse Practitioners in Women's Health, Papanicolaou Society, Pan American Health Organization, Planned Parenthood Federation of America, Society of Canadian Colposcopists,

Society of Gynecologic Oncologists, Society of Obstetricians and Gynaecologists of Canada.

SOURCE(S) OF FUNDING

These guidelines were developed with support by the National Cancer Institute grant 1 R13 CA 96190-01.

GUIDELINE COMMITTEE

Steering Committee for the 2001 Consensus Guidelines

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Thomas C. Wright, Jr, MD; J. Thomas Cox, MD; L. Stewart Massad, MD; Jay Carlson, DO; Leo B. Twiggs, MD; Edward J. Wilkinson, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Dr. Wright was the principal investigator of clinical trials investigating human papillomavirus (HPV) DNA testing and liquid-based cytology, funded by Digene Corp and Cytyc Corp via formal grants to Columbia University. Dr. Wright has no financial or equity interest in, ongoing consultancy with, or membership on the scientific advisory board of Digene Corp, which makes the only FDA-approved HPV DNA test in the United States. Dr. Wright currently serves on the speakers bureaus of Cytyc Corp and Tripath Inc, makers of liquid-based cytology test kits. Dr. Cox has previously consulted for Digene Diagnostics and has been on the Digene speakers bureau. He is also a consultant for 3M Pharmaceuticals, Cytyc Corp, and Merck, and is on the speakers bureau for 3M Pharmaceuticals and Cytyc Corp. He has no other financial interest in any company that might benefit from cervical screening guidelines. Dr. Massad was formerly the principal investigator of a grant to the Hektoen Institute correlating cervical disease with fluorescence data for SpectRx Inc. Dr. Twiggs currently serves on the speakers bureaus for Cytyc Corp and Tripath Inc. Dr. Wilkinson serves as a consultant for SpectRx and Welch Allyn, and is on the speakers bureau of Cytyc Corp.

Dr. Apgar has served on the speakers bureau of TriPath Imaging Inc; Dr. Ashfaq has received honoraria and travel expenses for lectures from Cytyc Corp; Dr Austin has been a speaker or consultant without personal compensation for AutoCyte Inc, Cytc, Digene Corp, Morphometrics, NeoPath Inc, Neuromedical Sciences Inc, and Veracel Inc; Dr Colgan has been a principal investigator for Neopath and AutoCyte, and has served as a consultant for Veracel; Dr Ferris has received honoraria from Cytyc and Digene, grants from Dytyc, and has served as a consultant for Digene; Dr Garcia has received research supplies from Cytyc and Digene, but has no financial interest in either; Dr Hunter has served on the speakers bureau of USHealthConnect and has served as principal investigator for a pilot study from LifeSpex Inc; Dr Kinney has received laboratory support and supplies from Cytyc and Digene (ending in 1997) for a study of ASCUS, and has served on the speakers bureaus of Cytyc and digene; Dr Krumholz has served on the speakers bureau of Cytyc; Dr Lonky is the Chairman of the Medical Advisory Board of, and is a shareholder and Director of, Trylon Corp, and has served on the

speakers bureau of 3M Corp; Dr Richart has served on the speakers bureaus of Cytyc and Digene, and is a shareholder of Digene common stock; Dr Sheets has served on the speakers bureau of Cytyc; Dr Sherman has received research support from Cytyc and Digene; Dr Spitzer has served on the speakers bureaus of 3M, Cytyc, and USHealthConnect, and has received research from Polartechnics Corp; Dr Walton own shares of Cytyc, and has received a Pap smear grant funded by Digene.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Society of Colposcopy and Cervical Pathology Web site.

Print copies: Available from the American Society of Colposcopy and Cervical Pathology, 20 West Washington St., Suite 1, Hagerstown, MD 21740.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Algorithm: Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN 1) and Satisfactory Colposcopy
- Algorithm: Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN 1) and Unsatisfactory Colposcopy
- Algorithm: Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 2 and 3 (CIN 2, 3)

Electronic copies: Available in Portable Document Format (PDF) from the American Society of Colposcopy and Cervical Pathology (ASCCP) Web site.

The following related guideline is also available:

- Wright TC Jr, Cox JT, Massad LS, Twiggs LB, Wilkinson EJ. 2001 Consensus Guidelines for the management of women with cervical cytological abnormalities. JAMA 2002 Apr 24;287(16):2120-9.

Electronic copies: Available in Portable Document Format (PDF) from the ASCCP Web site. See also the National Guideline Clearinghouse (NGC) summary.

Print copies: Available from the ASCCP National Office, 20 West Washington St, Suite 1, Hagerstown, MD 21740.

PATIENT RESOURCES

None available

NGC STATUS

This summary was prepared by ECRI on February 22, 2004. The information was verified by the guideline developer on February 24, 2004.

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